Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ahmed A Khalifa

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-14-2218-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On December 03, 2013 we submitted a fully completed HCFA form with supporting documentation related to the dates of service December 02, 2013 for payment processing. However, as of today we have yet to receive any payment or response. Therefore, per DWC rule 133.250(c)(2) please accept this letter as our request for reconsideration."

Amount in Dispute: $173.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier denied date of service 12/2/2013 as preauthorization was not obtained. Per a peer review obtained, ODG does not address office visits for chronic pain management. Therefore, per Rule 134.600, if treatment is not addressed for ODG, then preauthorization is required."

Response Submitted by: ESIS, P.O. Box 31143, Tampa, FL 33631-3143

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2, 2013	99214	$173.55	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 62 – No proof of pre-auth

Issues

1. Did the requestor support disputed services are payable?

2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204. Medical Fee Guideline for Workers' Compensation Specific Services(h) (5) states, "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier." Review of the submitted documentation finds the disputed charge is not related to pain management. The carrier's denial is not supported.
2. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99214 is:

   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

   The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

   - Documentation of the Detailed History
     - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed three chronic conditions, thus meeting this component.
     - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed four systems, this component was met.
     - Past Family, and/or Social History (PFSH) requires at least one specific item from any three history areas to be documented. The documentation found listed one area. This component was met.
   - Documentation of a Detailed Examination:
     - Requires at least six organ systems to be documented, with at least two elements per listed system. The documentation found (page 1 of occupational medicine follow up 12/2/2013) listed 1 body/organ systems: musculoskeletal. This component was not met.

3. Review of the submitted documentation finds that required elements of 28 Texas Administrative Code §134.203 have not been met. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.